State of Maryland

MD BOARD OF OCCUPATIONAL THERAPY PRACTICE

Spring Grove Hospital Center • 55 Wade Avenue • Bland Bryant Building
4th Floor • Baltimore, MD 21228
Phone: 410-402-8560 · Fax: 410-402-8561 · Website: http://dhmh.maryland.gov/botp

MORAL CHARACTER ENDORSEMENT FORM

The Maryland State Board of Occupational Therapy Practice is gathering information to determine whether the applicant for licensure to practice occupational therapy in Maryland can be anticipated to do so ethically. **Persons who complete this form must have observed the applicant's clinical skills, and not be related to the applicant.**

Name of Applicant: _____ Social Security Number: XXX-XX-_____

Address: _____ Email : _____

City/State/Zip: _____ Phone (_____) _____

License Type You Are Applying For:

Official License:	❑ OT	❑ OTA
Temporary License:	❑ OT	❑ OTA
Reinstatement:	❑ OT	❑ OTA
Reactivation:	❑ OT	❑ OTA

To the best of your knowledge, has the applicant:

	Must check Yes or No
1. Obtained appropriate licensure prior to practicing occupational therapy?	1. □ YES □ NO
2. Appropriately represented his or her skills?	2. □ YES □ NO
3. Complied with all applicable laws dealing with the practice of occupational therapy?	3. □ YES □ NO
4. Provided only those procedures, which appeared to be safe for the client?	4. □ YES □ NO

CONTINUED ON BACK

TDD FOR DISABLED
MARYLAND RELAY SERVICE
1-800-735-2258

FAX COPIES WILL NOT BE ACCEPTED.

If this form has been completed by someone who has not observed the applicant's clinical skills, it will be rejected and may delay the processing of this application.

Must check Yes or No

5. Provided appropriate services to clients without discrimination based on age, race, creed, national origin, sex, sexual orientation, handicap, or religious affiliation? 5. □ YES □ NO

6. Shown respect for clients' rights, including the right to refuse treatment? 6. □ YES □ NO

7. Avoided cruel, inhumane, or degrading practices in the treatment of clients? 7. □ YES □ NO

8. Provided the highest quality services to clients? 8. □ YES □ NO

9. Placed the needs of the client above personal gains, financial or otherwise? 9. □ YES □ NO

10. To the best of my knowledge, the applicant is of good moral character. 10. □ YES □ NO

11. How long have you been acquainted with the applicant? 11. _____ Months
_____ Years

12. Describe the manner in which you are familiar with the applicant's clinical skills.

_____

_____

_____

_____

13. I attest that the information provided is true to the best of my knowledge:

_____ _____
Name Signature

_____ _____
Job Title Date

_____ _____
Address City/State/Zip

(_____) _____ (_____) _____
Home Phone number Work Phone Number

DO NOT FORWARD THE COMPLETED FORM TO THE APPLICANT.
The completed **original** form must be returned directly to:

MD Board of Occupational Therapy
Spring Grove Hospital Center- 55 Wade Avenue
Bland Bryant Building, 4th Floor
Baltimore, MD 21228

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